PRINTED: 08/03/2011 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155307	B. WIN			07/18/2	011
		II			ADDRESS, CITY, STATE, ZIP CODE	<u>l</u>	
NAME OF I	PROVIDER OR SUPPLIER	8			RTHUR BOULEVARD		
TOWNE	CENTRE HEALTH			1	LLVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
F0000							
	This visit was fo	r the Investigation of	F0	000	Preparation and implementa		
	Complaint IN00093249.				of this plan of correction doe	s not	
	1				constitute admission or		
	Complaint IN00	093249 substantiated,			agreement by Towne Centre Health Care of the truth of the		
	1 1	ficiencies related to the			facts, findings, or other		
		ited at F 225, F 226, and			statements as alleged by the	÷	
	F 272.	nted at 1 223, 1 220, and			preparer of the survey/inspe		
	r 2/2.				dated 7-18-2011. Towne Ce		
		1 12 12 110 2011			Health Care specifically rese		
	Survey dates: Ju	aly 12, 13, and 18, 2011			the rights to move to strike of exclude this document as	·r	
					evidence in any civil,		
	Facility number:				administrative, and criminal	action	
	Provider number				not related directly to the lice		
	AIM number: 10	00284910			and/or certification of this factory or provider.	cility	
	Survey team:						
	Janelyn Kulik, R	N					
		1					
	Census bed type:						
	SNF/NF: 87	•					
	Total: 87						
	10tal. 67						
	Census payor typ	pe:					
	Medicare: 19						
	Medicaid: 55						
	Other: 13						
	Total: 87						
	101.1.0/						
	Sample: 8						
	These deficiencie	es also reflect State					
		accordance with 410 IAC					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

16.2.

Event ID:

67QG11

Facility ID:

000204

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155307		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP. 07/18/2	LETED	
	PROVIDER OR SUPPLIER		7250 AF	ADDRESS, CITY, STATE, ZIP CODE RTHUR BOULEVARD LLVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
F0225 SS=D	Quality review of Cathy Emswiller The facility must in have been found or mistreating resist have had a finding nurse aide registry mistreatment of resoftheir property; a has of actions by a employee, which we service as a nurse the State nurse aide authorities. The facility must eviolations involving abuse, including in and misappropriate reported immediate the facility and to with State law through (including to the Sagency). The facility must halleged violations and must prevent the investigation is the reported to the addrepresentative and accordance with State survey and oworking days of the survey and	ompleted 7/21/11 RN ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or gentered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for aide or other facility staff to de registry or licensing msure that all alleged g mistreatment, neglect, or njuries of unknown source ion of resident property are lely to the administrator of other officials in accordance ough established procedures tate survey and certification ave evidence that all are thoroughly investigated, further potential abuse while in progress. Investigations must be ministrator or his designated it to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective	TAG	DEFICIENCY)		DATE
		review and interview, the	F0225	F 225		07/30/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155307	B. WIN			07/18/2011
			B. WII.		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				RTHUR BOULEVARD	
TOWNE	CENTRE HEALTH	CARE		1	LLVILLE, IN46410	
(X4) ID	STIMMARAS	TATEMENT OF DEFICIENCIES		ID		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	facility failed to	ensure every suspected			Resident D was discharged to	from
	1 *	se was reported promptly			the facility.	
	_	ator, Indian State			All resident have the potenti	
	Department of H				be affected. Any bruise of unki	nown
	_				origin will be investigated and	
	_	1 of 2 residents reviewed			reported to the ISDH.	
	l "	inknown origin in a			 Residents with bruises of unknown origin will be immedi 	ately
	sample of 8. (Re	esident #D)			reported to the Administrator,	utory
					Director of Nursing (DON) or	
	Findings include	:			Administrative designee. Healt	h
					Care staff will be inserviced on	
	The closed recor	d for Resident #D was			reporting bruises by 7-30-11.	
	reviewed on 7/12	2/11 at 1:45 p.m. The			4) All residents receive weekly	I
	resident's diagno	ses included, but were			checks on shower days and brui	
	I -	emia, hypertension,			will be noted and reported to th Administrator, DON or	e
	cerebrovascular a				Administrative designee. The	
		s, and depression.			Administrator, DON or	
	diabetes, seizare.	s, and depression.			Administrative designee will ch	neck
	A nursing note d	ated 6/13/11 at 4:00 p.m.,			to see if the bruise has been	
		Ident was at the nurse's			investigated and reported to the	
	station and the n				ISDH. If the bruise has not bee	I
					reported, it will be reported at the time. All bruises will be review	
		oruise on the resident's			monthly in the QA Committee	/eu
		asked the resident how it			meeting ongoing.	
	-	resident stated, "I don't			5) Completed by 7-30-11.	
	1	pened". The resident				
	expressed no pair	n and was able to open				
	and close his mo	uth without difficulty.				
	The resident's lov	wer gum line was intact				
	with no bleeding	noted.				
	Interview with th	ne Administrator on				
	7/18/11 at 9:30 a	.m., indicated she could				
		she had been told about				
		e would have to check				
		as investigated and				
	into it the area w	ao mitodigalea ana				

l '		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
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TOWNE	CENTRE HEALTH	CARE			RTHUR BOULEVARD LLVILLE, IN46410		
	CENTRE HEALTH (L	LLVILLE, IN464 IU		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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IAG		LSC IDENTIFFING INFORMATION)	-	IAG	DEI TOLERO LY		DATE
	reported.						
	T	D: 4 N :					
		ne Director or Nursing,					
	I	nd LPN #1 on 7/18/11 at					
	· ·	ated the area was					
	~	the resident had indicated					
		nim. The injury of					
		was not reported to the					
	l '	partment of Health, and					
	1 *	re when the Administrator					
		ed of the bruise. The					
		ing indicated during a					
	_	11 a CNA had indicated					
	Resident #D wou	ald rest his chin on the					
		er when he was in the					
	bathroom. The A	Administrator then					
	indicated yes but	the bruise was observed					
	on 6/13/11. LPN	I #1 indicated the resident					
	had told her duri	ng an interview that no					
	one hurt him and	he would have told staff					
	if someone had h	urt him.					
	Interview with th	ne Director of Nursing on					
		p.m., indicated that when					
		ound on Resident #D's					
	chin the resident	was interviewed but no					
	staff or other resi	idents were interviewed					
	at that time.						
	This Federal tag	relates to Complaint					
	IN00093249.						
	11100073277.						
	3.1-13(g)(1)						
	3.1-28(c)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155307	B. WING			07/18/2	011
NAME OF PROVIDER OR SUPPLIER TOWNE CENTRE HEALTH CARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			7250 AF	ADDRESS, CITY, STATE, ZIP CODE RTHUR BOULEVARD LLVILLE, IN46410 PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	īE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0226 SS=D	written policies and mistreatment, negland misappropriation Based on record facility failed to a followed its abus reporting all alleg Administrator, In of Health and insunknown origin reviewed for injuring a sample of 8. Findings include: The closed record reviewed on 7/12 resident's diagnost not limited to, an cerebrovascular adiabetes, seizures. A nursing note date	d for Resident #D was 2/11 at 1:45 p.m. The ses included, but were emia, hypertension, accident (stroke), s, and depression. ated 6/13/11 at 4:00 p.m., dent was at the nurse's	F0.	226	F 2261) Resident D was discharged from the facility.2 residents have the potential taffected. Health Care staff winserviced on the Facility Abu Prevention and Reporting Poby 7-30-11.3) Any injury of unknown origin will be report the Administrator, DON or Administrative designee. Thinjury will be immediately investigated and reported to ISDH. All resident will have weekly body assessments completed on shower days. findings will be reported to the Administrator, DON or Administrative designee. 4) Towne Centre Executive Dire (ED) will monitor by comparing facility incident reports and the Reports sent to the ISDH to assure compliance. The ED report findings to the QA committee monthly ongoing. Some completed by 7-30-11	to be it it is it	07/30/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155307	B. WIN			07/18/2	011
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NAME OF	PROVIDER OR SUPPLIEF			7250 AF	RTHUR BOULEVARD		
	CENTRE HEALTH				LLVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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IAU	 	· · · · · · · · · · · · · · · · · · ·		IAU			DATE
		bruise on the resident's asked the resident how it					
	1 -	e resident stated, "I don't					
	1	opened". The resident					
	1 -	in and was able to open					
		outh without difficulty.					
	1	wer gum line was intact					
	with no bleeding	g noted.					
	The Abuse Preve	ention and Reporting					
	1	edure was provided by the					
	1 -	n 7/12/11 at 9:30 a.m.					
	The purpose of t	he procedure was as					
	1	ablish guidelines for					
		cedures that prohibit					
	1 ^	eglect and abuse of					
		appropriation of resident					
	1	assure the residents will					
	1 ^ *	, mental, sexual, or					
	1	corporal punishment, or					
	1	usion by implementing					
	1	creening, training,					
	1 ^	tification, investigation,					
	1 1	eporting/response to all					
	1 ^	use." The policy					
	_	owing: "It is the policy of					
		ealth Care to protect					
	1	streatment, neglect, and					
	1	t and misappropriate of					
	1	7. The facility will not					
		al, sexual, or physical					
	abuse, corporal p						
	1	usion. The facility will do					
	1	_					
	all that is within	its control to prevent					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155307		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 07/18/2	ETED	
NAME OF	PROVIDER OR SUPPLIER	}			ADDRESS, CITY, STATE, ZIP CODE		
				1	RTHUR BOULEVARD		
TOWNE	CENTRE HEALTH	CARE		MERRII	LLVILLE, IN46410	_	
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IAG	†	buse by screening and		IAG	,		DATE
		ees, protecting residents,					
	1	identifying, investigating,					
	1 1	nd to allegations of abuse,					
	neglect, mistreat	_					
	misappropriation	·					
		ncluded, but were not					
		of Unknown source:					
	"When both the	source of the injury was					
	not observed by	any person or the source					
	of the injury cou	ld not be explained by the					
	resident; and the	injury is suspicious					
	because the exte	nt of the injury or the					
	location of the ir	njury (e.g. (that is), the					
	injury is located	in an area not generally					
		uma) or the number of					
	1 *	d at one particular point in					
		ence of injuries over					
	time."						
	I -	neans as soon as possible,					
		ceed 24 hours after					
		incident, in the absence					
		timeframe requirement."					
	1 ^	included, but were not					
		ification: "The facility					
	1	bruising of unknown					
	"	by be suspicious in nature					
	_	o attempt to determine					
	cause. An include completed and re	ent report will be					
	_	ediately. Any injury of					
	_	must be investigated if					
		are met: the source of the					
		bserved by any person or					
	I mjury was not o	osor ved by any person or					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155307		A. BUII	A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/18/2011	
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	explained by the suspicious in nat of the injury or the ect." Investigation implement an Alteriotocol. The provided and/or Director Mathematical Administrator and Nursing) will provinvestigation by statements of informeroring Initial authorities." "j) will be conducted limited to obtain alert and oriented members, witness time, at different different floors, or Reporting/Respoor designee will (Indiana State Dottelephone (telephone (telephone) or by e-24 hours upon deexists or existed the ISDH guidelit occurrences."	or DON (Director of occed with the obtaining initial formation relative to Report to the proper A thorough investigation d including, but not ing statements from other d residents, staff, family uses to the event, at the times or shifts, on					
	7/18/11 at 9:30 a	.m., indicated she could					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155307		A. BUII	LDING	NSTRUCTION 00	COMPL	ETED
		,	7250 AF	RTHUR BOULEVARD		
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
the bruise and sh	e would have to check					
Administrator, and 10:00 a.m., indication one had hurt I unknown original. Indiana State Deathey were not such had been informed Director of Nursemeeting on 6/23/Resident #D wout toilet paper hold bathroom. The Administrated yes but on 6/13/11. LPN had told her during one hurt him and if someone had I Interview with the 7/18/11 at 12:43 the bruise was for chin the resident staff or other restat that time.	and LPN #1 on 7/18/11 at sated the area was the resident had indicated him. The injury of was not reported to the partment of Health, and re when the Administrator ed of the bruise. The ing indicated during a 1/11 a CNA had indicated ald rest his chin on the er when he was in the Administrator then at the bruise was observed I #1 indicated the resident ing an interview that no I he would have told staff nurt him. The Director of Nursing on p.m., indicated that when bound on Resident #D's was interviewed but no idents were interviewed					
This Federal tag IN00093249.	relates to Complaint					
	SUMMARY S (EACH DEFICIEN REGULATORY OR not remember if the bruise and sh into if the area w reported. Interview with th Administrator, at 10:00 a.m., indic investigated and no one had hurt I unknown origin Indiana State De they were not such had been informed Director of Nurs meeting on 6/23/ Resident #D wor toilet paper holde bathroom. The A indicated yes but on 6/13/11. LPN had told her duri one hurt him and if someone had h Interview with th 7/18/11 at 12:43 the bruise was for chin the resident staff or other resident staff or other resident at that time.	DENTIFICATION NUMBER: 155307 PROVIDER OR SUPPLIER CENTRE HEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) not remember if she had been told about the bruise and she would have to check into if the area was investigated and reported. Interview with the Director or Nursing, Administrator, and LPN #1 on 7/18/11 at 10:00 a.m., indicated the area was investigated and the resident had indicated no one had hurt him. The injury of unknown origin was not reported to the Indiana State Department of Health, and they were not sure when the Administrator had been informed of the bruise. The Director of Nursing indicated during a meeting on 6/23/11 a CNA had indicated Resident #D would rest his chin on the toilet paper holder when he was in the bathroom. The Administrator then indicated yes but the bruise was observed on 6/13/11. LPN #1 indicated the resident had told her during an interview that no one hurt him and he would have told staff if someone had hurt him. Interview with the Director of Nursing on 7/18/11 at 12:43 p.m., indicated that when the bruise was found on Resident #D's chin the resident was interviewed but no staff or other residents were interviewed at that time. 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LPN #1 indicated the resident had told her during an interview that no one hurt him and he would have told staff if someone had hurt him. Interview with the Director of Nursing on 7/18/11 at 12:43 p.m., indicated that when the bruise was found on Resident #D's chin the resident was interviewed but no staff or other residents were interviewed at that time. This Federal tag relates to Complaint	ROVIDER OR SUPPLIER CENTRE HEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) not remember if she had been told about the bruise and she would have to check into if the area was investigated and reported. Interview with the Director or Nursing, Administrator, and LPN #1 on 7/18/11 at 10:00 a.m., indicated the area was investigated and the resident had indicated no one had hurt him. 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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155307			A. BUILDING B. WING	00	COMPLETED 07/18/2011	
	PROVIDER OR SUPPLIER		7250 A	ADDRESS, CITY, STATE, ZIP CODE RTHUR BOULEVARD LLVILLE, IN46410	1	
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F0272 SS=D	standardized repro- each resident's fur A facility must make assessment of a re RAI specified by the must include at lead Identification and of Customary routine Cognitive patterns Communication; Vision; Mood and behavion Psychosocial well- Physical functioning Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentian Documentation of regarding the additiperformed through protocols; and	prehensive, accurate, oducible assessment of national capacity. The accomprehensive desident's needs, using the ne State. The assessment dest the following: demographic information; The patterns; The patterns; The accomprehensive demographic information; The accomprehensive demographic information; The accomprehensive desident's needs, using the needs of the second of the s				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
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		155307	B. WIN			07/18/2	011
NAME OF E	PROVIDER OR SUPPLIER	,	-	STREET.	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	ROVIDER OR SUFFLIER			7250 A	RTHUR BOULEVARD		
	CENTRE HEALTH				LLVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		review and interview ,the	FO	272	F 272 1) Resident is using correct lift	for	07/30/2011
	1 *	assess a resident's transfer			transfer.	. 101	
	status for 1 of 6	residents reviewed for			2) All residents have the poten	tial to	
	falls in a sample	of 8 related to a resident			be affected. All new residents,		
	returning from th	ne hospital with a			re-admitted residents or residen	its	
	fractured humeru	as and her arm in a sling.			with a change in status will be		
	(Resident #C)	·			assessed for correct transfer sta		
					3) Nurses will be inserviced or		
	Findings include	•			Assessing Resident for Correct		
	i mamgs merade	•			Transfer Status by 7-30-11. Up completion, the results of the	OOH	
	The record for P	esident #C was reviewed			Transfer Assessment will be wr	ritten	
		resident's diagnoses			on the Nursing Assistant		
		•			Communication Sheet.		
	· ·	re not limited to, anxiety,			4) All new residents, readmitte		
		der, and congestive heart			residents or residents with chan		
	failure.				status will be monitored by the		
					Unit Managers or Weekend Nu		
	A nursing note d	ated 4/17/11 at 5:30 p.m.,			Manager 7 days per week, to as the correct transfer status has be		
	indicated the res	ident was found on the			identified and communicated to		
	floor in the dinin	ig room. There was no			direct care staff per the Nursing		
	apparent injury r	noted at this time. The			Assistant Communication Shee		
	resident indicate	d she hit her head on the			The DON will report to the QA		
	floor. There was	s no bleeding or open					
					1	and	
		_					
	1 ^				5) Completed by 7-30-11.		
		_					
	_						
	-						
		-					
	mactured tert nur	merus (upper arm bone).					
	Review of a Res	ident Assessment-Data					
	Collection Form	dated 4/21/11, indicated					
	resident indicate floor. There was areas noted. The left arm pain. A send the resident p.m. a call was remergency room was admitted to fractured left hun. Review of a Res Collection Form the resident had	d she hit her head on the sono bleeding or open the resident complained of the norder was received to the hospital. At 11:15 deceived from the solution indicating the resident the hospital with a smerus (upper arm bone).				oring	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPI	ETED
		155307	B. WIN			07/18/2	011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1	RTHUR BOULEVARD		
TOWNE	CENTRE HEALTH	CARE		1	LLVILLE, IN46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	leg. She was a t	wo person assist for					
	transfers.						
	A nursing note dated 4/21/11 at 9:00 p.m., indicated the resident had a bruise to her						
		rith a fractured left upper					
	1	ained of pain when					
		n was in a sling at this					
	time.						
	A nursing note d	lated 4/22/11 at 10:00					
	a.m., indicated t	he resident's arm sling					
	was intact. The	resident denied					
		ss being repositioned.					
		ss cents repositioned.					
	A nurging note d	lated 4/26/11 at 10:00					
	_						
	· ·	he resident's left upper					
		was intact. Her hand					
	1	The resident complained					
	of pain when be	ing repositioned or					
	moved.						
	A nursing note d	lated 4/27/11 at 2:45 p.m.,					
	· ·	ident was a 1-2 person					
		fractured left humerus, to					
		a sling. She had					
		_					
		nin and discomfort					
	whenever the ar	m was moved.					
	A	lata 4 4/20/11 at 10.55					
	1	lated 4/29/11 at 10:55					
	1 -	he resident continued to					
	wear a sling to h	er left arm due to a					
	fractured humer	us. Her arm was still very					
		ment and her range of					

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155307	B. WIN			07/18/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEF	8			RTHUR BOULEVARD		
TOWNE CENTRE HEALTH CARE			1	LLVILLE, IN46410			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE	
	motion was limit	ted.					
	A nursing note d	ated 4/30/11 at 1:25 a.m.,					
	_	ident continued to wear a					
		arm due to a fractured					
	1	esident complained of no					
		ort at this time. However,					
	_	ft arm was moved the					
	resident complai	ned of pain.					
		1.5/0/11					
	_	ated 5/2/11 at 11:36 a.m.,					
		ident continued with a					
		numerus fracture. The					
	resident complai	ned of left arm pain. The					
	resident was a tv	vo person assist for					
	activities of daily	y living and transfers,					
	using a hover lif	t (a mechanical transfer					
	1 -	order was received to					
	· · · · · · · · · · · · · · · · · · ·	ra lift (a mechanical lift,					
	sit to stand lift) and start hoyer lift due to left humerus fracture.						
	ion numerus mad	жи. С.					
	Pavian of a phy	sician order dated 5/2/11					
		dicated fractured left					
		ntinue Sara lift for					
		w order for use of a hoyer					
	lift for all transfe	ers.					
	A discharge Min						
		d 4/19/11, indicated the					
	resident was an e	extensive assist with					
	transfers, indicat	ing the resident involved					
	in activity, staff provided weight-bearing						
		person physical assist.					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED			
1		155307	B. WIN			07/18/2	011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF PROVIDER OR SUPPLIER					RTHUR BOULEVARD			
TOWNE CENTRE HEALTH CARE			MERRILLVILLE, IN46410					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEBUGINGS DESCRIPTION SHOULD BE		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
TAG	A significant charal Assessment date resident was total transfers requiring every time during two plus persons. Review of a physic treatment dated a resident's prior less transfers, sit to significant with the level of function 100% assistance to transfer. She is 6 on a scale of 10 in her bilateral slip in her bilateral slip in her bilateral slip in her bilateral slip in this was being the lift but this was being the	sical therapy plan of 4/22/11, indicated the evel of functioning for stand and stand to sit was ce routinely requiring transfer. Her current was dependent requiring by one or more persons had pain with activity of 0. The pain was located houlders. In for Sara Lift Form was Director of Nursing 1 at 2:50 p.m. She was no policy for the Sara now the CNAs were earlift. The procedure is not limited to, "Ensure each and hold onto lifting process."		TAG	DEFICIENCY)		DATE	
	7/12/11 at 2:30 p Lift should not b	hysical Therapist #1 on o.m., indicated the Sara se used on a resident with erus and arm in a sling.						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPL	ETED	
155307		B. WING			07/18/2011		
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1	RTHUR BOULEVARD		
TOWNE CENTRE HEALTH CARE				MERRII	LLVILLE, IN46410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONTROL OF CONTROL		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	At 2:45 p.m. the Therapist indicated						
		uld not have been a Sara					
	Lift due to the contractures of her bilateral legs. He further indicated she should not have been a Sara Lift prior to her humerus fracture.						
	Interview with the	ne Second Floor Unit					
	Manager on 7/13	7/11 at 7:30 a.m.,					
	indicated that wh	nen a Resident is admitted					
	or readmitted to the facility the transfer						
	method would be determined by therapy. The resident's are left in bed until therapy						
	evaluates.						
	evaluates.						
	Interview with Physical Therapist #1 on						
		.m., indicated therapy					
		determine the initial					
	1	er. If the resident would					
	be admitted to the facility on a Saturday the resident would not be left in bed until the therapist evaluated the resident. At 7:40 a.m. the therapist indicated Resident #C was evaluated on 4/22/11 as dependent and should not have been a Sara Lift.						
	Interview with th	ne Director of Nursing on					
	7/13/11 at 3:05 p	.m., indicated the CNA					
		4/18/11 and 4/24/11 for					
	Resident #C indi	cated the method of					
	transferring the r	esident was the Sara Lift.					
	1	ated the method of					
		discussed in morning					
		NAs had come to her and					
	1	mad come to mor and					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION ID		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING 00 CO		(X3) DATE SURVEY COMPLETED
		155307	B. WING		07/18/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE RTHUR BOULEVARD	
TOWNE CENTRE HEALTH CARE			MERRI	LLVILLE, IN46410	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	transfer Resident with her arm in a indicated it was a transfer was char also indicated the mentioned the re with transfers.	vas appropriate to the a #C with the Sara Lift a sling. She further at this time the method of niged to a hoyer lift. She a staff had never sident was having pain relates to Complaint			